Biological
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The Maritime medical news

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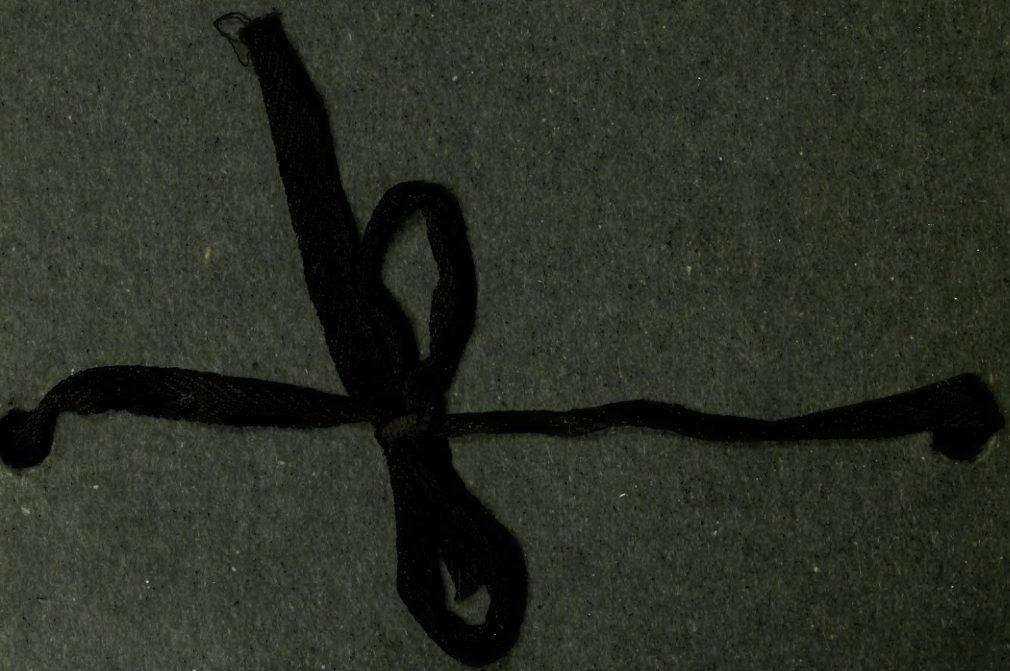
(1906-07)



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THE MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO MEDICINE & SURGERY

VOL. XVIII HALIFAX, NOVA SCOTIA, JANUARY, 1906. NO. 1

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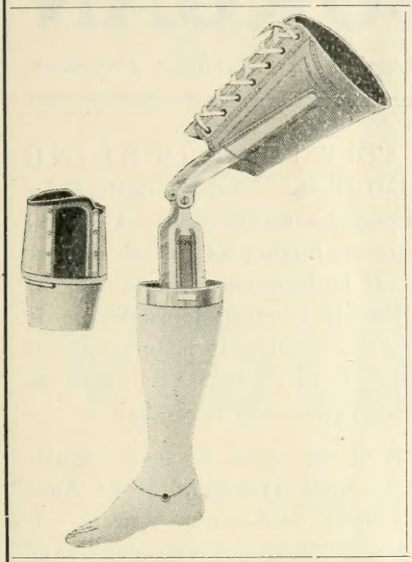

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THE MARITIME MEDICAL NEWS is a monthly magazine devoted to the interests of the medical profession. Communications of general and local professional interest will be gladly received from friends everywhere. Manuscript for publication should be legibly written in ink (or typewritten, if possible) *on one side only* of white paper. All manuscripts and correspondence relative to letter press should be addressed to The Editors, Maritime Medical News, P. O. Box 341, Halifax, N. S.

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THE
MARITIME MEDICAL NEWS

VOL. XVIII., *JANUARY, 1906*, No. 1

The Surface Tension of Urine

Of late years a number of new physico-chemical methods have added to the accuracy with which we may estimate variations in the urine. The determination of the freezing point has come to be part of the routine work of urinalysis by many careful clinicians. The viscosity, the electrical conductivity and the refractive index of the fluid have also received minute study of late, and will doubtless in time be considered in the practical work of clinical laboratories. Quite recently the question of surface tension of the urine has attracted the attention of several investigators. W. G. Donnan and F. G. Donnan contribute a short article on the subject to the *British Medical Journal* of Dec. 23, 1905, and describe simple apparatus for clinical estimation. In health the surface tension varies considerably, being low in the morning, and being reduced by exercise, etc., a fact which must be taken into account. A high density is not necessarily associated with a low surface tension, although this is commonly the case. In all cases of catarrhal jaundice examined, the surface tension was found to be abnormally low, and to rise progressively to the normal as the jaundice passed off. Few other morbid conditions were studied, and in such as were investigated no definite or constant results were obtained.

The Danger of Light

Fresh air and sunlight have had so great a vogue for some years now, that it is not surprising to find that someone has come forward to show that we have again been following a wrong scent, and that prolonged exposure to sunlight is not only not beneficial but actually injurious. So excellent an authority as Major Charles E. Rutherford, U. S. A., has published a paper in the *Medical Record* of Dec. 23, 1905, in which he asserts that excessive light injures the animal organism, the prejudicial effect being produced by the shorter light waves. Light, he argues, almost invariably hinders growth, while darkness favours it both in plants and animals. The opinions of botanists and geologists are cited in support of his contention. "Zoologists also have shown that animals pass all their time in the dark, or if they must expose themselves to

the sun's rays they are invariably protected by an opaque covering of hair, feathers, or skin pigmentation. It is only within a decade that anthropologists have discovered that the same law applies to man. It is now proved that in every part of the world the native type of man, who is adjusted to the climate, has an amount of pigmentation strictly in accordance with the amount of light to which he is exposed." The short rays have a more destructive effect upon invading organisms and a typical new cells than upon normal tissue, and because of this have a therapeutic influence, but if the light is too strong it injures normal tissue as well as abnormal.

Modern Treatment of Insanity

At the sixth New York State Conference of Charities and Correction, Dr. William Mabon, president of the State Commission in Lunacy, discussed the care of the mentally defective. He referred to the value of occupation as an adjuvant to the treatment of the insane. In speaking of hospital treatment he announced that the Commission in Lunacy (of New York State) "proposes to urge upon the legislature, at its forthcoming session, the desirability of providing special appropriations for the construction of small acute hospitals, accommodating from sixty to eighty patients each, in connection with such of the existing state hospitals as are not at the present time properly equipped for the care of acute cases. The absolute necessity of providing every possible facility for the care of curable patients, not to mention the true economy of such procedure, must be apparent to every novice in social economy." At the same meeting Dr. Bertha A. Rosenfeld made a strong plea for the care of the insane outside of special institutions. "Let us deplete the ever-growing supply of mental invalids to the big institutions," she said. "Let us prevent many acute cases from becoming chronic by giving them real care from the first." She argues for the establishment of mental wards in connection with general hospitals. This was done some years ago at the Albany Hospital, and strikingly good results have followed.

The Moving Picture in Medicine

We have long been treated to lantern demonstrations of morbid conditions, and now the moving picture has been utilized to illustrate epileptic seizures. This novel method of illustration was introduced at a recently held meeting of the National Association for the Study of Epilepsy, held at New York Academy of Medicine. The pictures, numbering in all more than 37,000, were taken at the Craig Colony for Epileptics, at Sonyea, N. Y., and very accurately reproduced the various phases of actual epileptic

convulsions. While this is not the first adaptation of the moving picture to the illustration of medical subjects, it is still sufficient of a novelty to attract attention.

Death of A Medical Explorer.

Medical men have been among the most conspicuous pioneers in the exploration of unknown lands. The names of doctors are writ large in the history of colonization. The most casual mention of the subject recalls the names of Mungo Park, David Livingstone, Sir John Roy, Emin Pacha, and Sir John Kirk, to mention only the first that come to mind. Another has recently passed away in the person of Dr. Jean Marie Bayol. Born in 1849, he entered the French navy as a medical officer. He was attached to the expedition under Captain (now General) Gallieni, who in 1880 was commissioned to explore the region of Africa extending from the confluence of the Bafing and Bakoy rivers to Bammako on the Niger. He was afterwards placed in charge of an expedition to the Fonta-Djallon region, now French Guiana, and he succeeded in getting it officially recognized as a French protectorate. Having taken a prominent part in extending French influence in Central and West Africa, Dr. Bayol was, in 1889, appointed Lieutenant-Governor of the Rivieres du Sud provinces and dependencies. In that capacity he visited Dahomey with the object of negotiating a fresh treaty with King Gle-Gle, who had refused to be bound by one made with France in 1878. In was an arduous and dangerous undertaking. Although the King consulted him nearly every day about his health, Bayol had to endure much insolence at the hands of the heir to the throne. He was forced to walk between two rows of human heads just cut off, and to be present at human sacrifices. The mission was a failure, Prince Kondo declaring that since France had chosen to allow itself to be governed by a woman—to wit, the Republic—treaties previously signed with that country might be regarded as null and void. The King died and was succeeded by Kondo, who took the name of Behanzin. His attitude toward the French became so aggressive that a punitive expedition had to be sent out under General Dodds. Dr. Bayol again narrowly escaped death at the hands of the hostile natives when he was governor of the Benin Settlements on the Ivory Coast. Owing to failing health, Dr. Bayol retired a few years ago with the title of Honorary Colonial Governor and returned to France. His energetic spirit would not, however, allow him to stand aloof from public life. He was elected to the General Council of the Bouches-du-Rhone Department, which he afterwards represented in the French Senate. His name deserves to be added to the ever-

lengthening list of members of our profession who have done splendid service to their country as explorers and administrators *in partibus infidelum.—Medical News.*

Medical Literature Exchange Dr. T. D. Crothers, of Hartford, Conn., desires the names of medical men interested in the literature of inebriety, alcoholism, drug-taking, etc. The object is to obtain a list of physicians who would like to receive reprints, papers, and abstracts on these subjects; also to establish a bureau for advice concerning the problems centering about the use of alcohol.

Epilepsy Prize At the Fifth Annual Meeting of the National Association for the Study of Epilepsy, held in the Academy of Medicine, New York, on November 29th, 1905, the President, Dr. W. P. Spratling, announced that the Association offered a prize of $300 for the best essay on the etiology of epilepsy. Physicians in any country may compete for this prize. The award will be made in November 1906, but all essays submitted must be sent in by September 1st. Details as to conditions governing the award may be obtained from Dr. Spratling, Superintendent of the Craig Colony for Epileptics, Sonyea, Livingston County, New York. Quite likely there are some Maritime men who would like to enter this competition.

International Medical Congress The Fifteenth International Medical Congress will assemble at Lisbon, Pôrtugal, during the week from the 19th to 26th of April 1906. The official language of the Congress will be French but in the general sessions as well as in the meeting of sections in addition to French, English and German will be made use of. There will be in all seventeen sections. The President is Conz Costa Alemao, and the Secretary-General is Professor Miguel Bombarda of Lisbon, to whom all general communications regarding the reading of papers may be addressed. Most of the countries will be fully represented at the Congress through the National Committees. For the United States Dr. John H. Musser of Philadelphia is President and Dr. Ramon Guiteras is Secretary. The Executive Committee of the Canadian Medical Association has appointed Dr. A. McPhedran as President and Dr. W. H. B. Aikins as Secretary for Canada, to act in conjunction with the International Committee of the Congress. It is desirable that the Canadians who propose to attend this Congress should put themselves in communication as soon as possible with either of the above named, and it is hoped that Canada will have a large representation at this meeting, as it will be the first International Congress at which Canada will have national representation.

Professional Ethics Again The old question of professional ethics, as applied to advertising by physicians, is agitating the New York County Medical Society. The trouble is due, says an exchange, quoted by *The Medical Age*, to a large number of the society's members, including the president, paying to have their names in a telephone directory, in what are declared to be advertisements. It is the unwritten law of the County Medical Society that no physician shall advertise, display a sign telling of the specialty he practices, or even note his work on his professional card. Several of the members of the society are insisting that the offenders be expelled.

❦

Sex and Brain "Mr. Marchand, of Marbourg," according to *The Family Doctor*, "has published the comparative weight of the brain at different ages and in different sexes. He finds the mean weight of the adult male brain to be 3 lbs. 1 oz., while that of the female averages 2 lbs. 10 oz. The disparity, if true, is significant with relation to the distinct purposes for which the sexes, respectively, are equipped by nature, and with reference to that other and more productive brain centre which distinguishes woman for her office and disposition. The present rage for bringing up the intellectual brain of woman to a parity with that of man may be successful, but it can be only a transfer of the true womanly brain from its divine seat to a different place and function. Neither sex is gifted with vital power to grow the other sex upon itself as a double and become mentally bi-sexed. One possible attendant on the effort, and a not unnatural one, is suggested by the investigations of Professor Limer, of Berlin, into the causes of insanity among women. He has come to the conclusion that if women are admitted into competition with men the inevitable result will be a tremendous increase of insanity. He finds that the percentage of women teachers who become insane is almost double that of the men teachers. Inquiries were also made about women employed as telegraphists, sales-clerks, and in the telephone service, and furthermore with regard to women employed in Swiss watch-making. These inquiries showed that in the occupations mentioned a far larger proportion of women than men succumbed to mental diseases.

❦

Free Hospital for Consumptives In the two institutions at Muskoka (the Cottage Sanatorium and the Free Hospital for Consumptives) over 2,000 patients have been cared for since the work began, and at the present time there are under treatment 150 patients—75 in each building. No patient has ever been refused admission to the Free Hospital for Consu-mp tives because of poverty, which has

been made possible through the generous contributions of friends from all parts of Canada. The trustees have recently decided to increase the accommodation by twenty-five beds, which will add heavily to the burden of maintenance. Patients have been admitted from every province of the Dominion, and the trustees hope that their appeals will meet with hearty response from Canadians everywhere. The Government of Ontario has promised an appropriation not only towards increased accommodation but to provide for the installation of a water and sewerage system. It is estimated, however, that $50,000 additional will be wanted this year. Any intending contributors can obtain further information by application to the NEWS.

The Hospital Investigation.

Nothing has excited so much interest in medical circles in Nova Scotia of late years as the recent investigation into a charge that a patient named Lively had come to his death because of neglect and improper treatment in the Victoria General Hospital. The man had been kicked by a cow, and sustained a rupture of the urethra. The practitioner who first saw the case, recognizing its gravity, advised removal to the hospital, to which he was admitted a few hours after the accident. At one time he suffered from retention of urine, occasioned by the catheter becoming blocked. There were some indications of sepsis, but the condition of the patient did not excite any apprehension until a very short time of his death, which occurred suddenly, and was considered by the attending surgeon to have resulted from pulmonary embolism.

The investigation was conducted by the Honourable Commissioner of Public Works and Mines, who evidenced a desire to have the matter thoroughly sifted out. The friends of the deceased patient and the medical board of the hospital were each represented by counsel. As the Honourable Commissioner has not yet made known his judgment in the matter, we cannot make specific comment upon the case.

But there were certain features of the investigation to which reference may quite properly be made at the present time. One of these was the evident determination of a local newspaper to give the worst possible interpretation to the evidence. Carelessness on the part of those engaged in hospital work is not to be condoned, but there is surely a better way to correct abuses in an institution than by giving red-typed publicity to sensational and unfair accounts of a public investigation, and thus to create a feeling of distrust and lack of confidence in a charity which is really doing very excellent work.

It was made perfectly apparent during the investigation that a very good doctor may make a very bad witness. The fairness of the

methods of a lawyer who badgers and harasses a witness into a state of mind which prevents clear thought and favours lapsus linguæ, may well be called in question. And it is not impossible that had the "prosecuting" attorney been less insistent upon having the answers he wanted to strengthen his cause, a more accurate and more just record of data would have been obtained.

Laxness in the keeping of records was shown, and the Honourable Commissioner may find that in this particular case, too much was left to improperly trained individuals, and that scarcely sufficient oversight was given by those most directly responsible. But it cannot be gainsaid that the hospital has been steadily increasing in efficiency of late years, and that it merits the confidence of the public as much to-day as ever it did. The prominence given to comparatively trivial defects in its management will doubtless stimulate those who have been negligent to better effort in the future, and it may be reasonably expected that out of the undoubted evil of this investigation good will come.

British Medical Association.

The success of the Montreal Meeting of the British Medical Association, in 1897, encourages us to look forward to the meeting to be held in Toronto in August of this year, with the confident expectation that it will be in every way creditable. It is a compliment to Canada that the premier medical organization of the English speaking world should elect to meet within our borders twice within a single decade. For this reason every Canadian physician should feel an interest in the approaching meeting, and should put forth what endeavour he can to make it successful. No one can doubt that the Toronto brethren will exert themselves to the utmost, and that the arrangements which they will make will prove in every way satisfactory. The efforts which they make should be heartily seconded by members of the profession throughout the Dominion. So exceptional an opportunity of meeting with the leaders in British medical circles should prove an irresistible attraction, and Toronto should be the Mecca of a vast pilgrimage of Canadian medical men in August.

In this connection it is perhaps not unwise to suggest to non-members of the British Medical Association the advisability of at once joining the association. The membership fee (one guinea) includes subscription to the *British Medical Journal*, and by joining early, a complete file of the *Journal* for the year can be secured. It is of course desirable that those who intend applying for membership should associate themselves with the nearest local branch.

THE SURGERY OF THE STOMACH IN NON-MALIGNANT CONDITIONS.

By GEORGE E. ARMSTRONG, M. D.,

Associate Professor of Clinical Surgery, McGill University, Montreal.

(Read before the Canadian Medical Association, Halifax, N. S., August 23rd, 1905.)

ONE of the fields of surgery largely extended during the past few years is that of the stomach and duodenum. We now deal not only with conditions which may be called strictly surgical, such as perforations, malignant disease and pyloric stenosis, but are sometimes able to render valuable aid to the physician in cases of persistent and frequently recurring small and large alarming hæmorrhages, as well as in chronic ulcer and its sequelae.

Perforation of the stomach or duodenum from ulcer calls for surgical aid, as peremptorily as from traumatism. I have closed five perforations of the stomach and one of the duodenum. They all recovered but one, a mortality of 16⅔%. Three of the stomach cases occurred in women and two in men. Their ages were from 21 to 40 years. The perforation was closed, in one 8 hours; in one 11½ hours; in one 24 hours; in one the time of perforation could not be definitely determined, as the man had had attacks of sharp pain in the epigastric region occurring at intervals for four days. In the fatal case the patient was admitted to the surgical side of the Montreal General Hospital 32 hours after perforation had occurred. The hole was closed at once and the pelvis drained through a second small incision. The patient died 4 days later of peritonitis. They all gave a history of indigestion, and in most of them a diagnosis of gastric ulcer had been made at some time previously.

In four of the six cases the perforation followed a period of from 30 days to one year, during which time they had been quite well and free from their old symptoms.

In the five cases the perforation was on the anterior wall. In one nearer the great curvature, in one about the centre of the anterior wall, and in three nearer the lesser curvature from ¼ inch to 4 inches from the pylorus.

The duodenal perforation was just outside the pylorus.

Mr. Moynihan divides perforations into three classes, acute, subacute, and chronic. Two of my cases might be classed as chronic. In one, and it was my first, I readily found the small perforation. It was about a quarter of an inch in diameter, and surrounded by a thick layer of fibrin, and when

this thick layer of fibrin was stripped off I had an opening in the anterior wall of the stomach three inches long. The edges were smooth and rounded.

In another case, an apparently small perforation came to admit three fingers when all the fibrin had been removed. Both of these cases did well. It would seem that in these cases an adhesive peritonitis, joining in my cases the anterior wall of the stomach to the under surface of the liver, occassioned before actual perforation took place. Finally, owing to failure of the process, extension of the ulceration and probably distension of the stomach, an opening formed and contents escaped.

Another case illustrates what may be called the subacute perforation.

A young man 25 years of age gave the following history. On a Monday about 4 or 5 o'clock in the afternoon he felt sick, but continued to work until six o'clock. That evening he took no supper, not because of pain, but because he had no appetite. He retched two or three times, but slept well that night. On Tuesday and Wednesday he worked as usual and took his meals, which caused him no pain or nausea. On Thursday he took no supper, and during the evening retched 2 or 3 times. On Friday at 4 p. m. he was suddenly seized with severe epigastric pain which radiated along left costal border. He vomited 3 or 4 times; no blood in vomitus. He stopped work and went home. He took no supper. During Friday night the pain was very severe. He was admitted to the hospital at 11 a.m. on Saturday. His temperature on admission was 98 and his pulse 96. His board-like abdomen did not move during respiration. At 12 noon his temperature had gone up up to 101 1-5 and his pulse to 104. I operated at 1 o'clock, found the perforation and closed it.

In another case when the abdomen was opened the little perforation was found temporarily closed by a firmly adherent layer of lymph, and I found no evidence of gas or stomach contents in the peritoneal cavity.

This and the two cases of chronic perforation already mentioned teach us how, under favourable conditions, such as an empty stomach, and good reparative power, a minute perforation may be temporarily closed by lymph, omentum or adhesions.

The prognosis in perforations of the stomach is much better than in perforations of the small intestines, or vermiform appendix. The infection is less virulent, and possibly us suggested by Treves, the peritoneum here has greater resisting power. In the stomach cases quantities of sero-purulent matter and jelly-like substance may be removed during the operation for closure and the patient recover. Abdominal rigidity occurs earlier and is more general and board-like.

In operating a search for other ulcers should be made. In one case after closing the perforation of the anterior wall, I unfolded the thin base of a second ulcer on the posterior wall. Closure was affected by a double row of continuous Lembert's or Halsted's sutures, the first row of catgut, the second of fine silk.

If evidences of other ulcerations were present, or the perforation was at the pylorus, I think a gastro-enterostomy would be indicated. I have not done it in any of my cases. The results have been satisfactory and there has not been any relapse so far as I know.

In the case of the duodenal perforation a gastro-enterostomy was indicated, as a preventive of recurrence, duodenal ulcers being ascribed to contact with irritating stomach contents, but the man's condition did not warrant it.

If evidence of a generalized spread of infection is present, the pelvis should be drained through a small incision.

Hæmorrhages.

Accumulating experience is gradually developing better defined views as to the time and method of attempting to control hæmorrhage from the stomach and duodenum. As Mr. Moynihan has well said, hæmorrhage may be the earliest and perhaps for a time, the only symptom of gastric disturbance, or it may be the last symptom in a long and tedious course of symptoms.

Of the six cases four recovered. One died suddenly on the eighth day after operation. At the autopsy there was found a double pulmonary thrombosis, the abdominal condition being quite satisfactory; and one died a month after operation of double suppurative parotitis. There had been no further hæmorrhages and the stomach and abdominal incisions were perfectly healed.

In small recurring hæmorrhages from chronic ulcer, there is a pretty general unanimity of opinion that surgical methods should be adopted, when rest and dieting faithfully carried out by patient and physician have failed to arrest the bleeding; when the patient is losing more blood than is being made and a hazardous degree of anæmia is threatening. It goes without saying that aneurism, leukæmia, and hepatic cirrhosis with portal obstruction, should be carefully excluded.

It is much more difficult to decide when to interfere in recurring large, copious hæmorrhages. That as a rule there is a natural tendency to limitation of the recurrence is generally recognized, and taught. That they may go on to a fatal issue in spite of rest, abstinence from food, ice, opium, supra-renal capsule, etc., has been demonstrated many times over.

When, then, can we stand by, and when should we advise action?

It is said that in cases without a previous history of gastric

derangement, there is less likelihood of the hæmorrhages proving lethal. This may be true—I have not had a sufficiently large experience to form an opinion on this point—but I may say that in one of my cases the patient had never had any stomach trouble whatever until the hæmorrhage started. In spite of all that an accomplished and successful physician could do these hæmorrhages continued to recur at comparatively short intervals for 7 days. The patient was then almost exsanguinated, and in his opinion, with which I fully concurred, would certainly have died had not the stomach been opened and the bleeding arrested. Further experience may demonstrate that we can afford to wait longer when the bleeding is from an acute than when it is from a chronic ulcer, but in my opinion we must judge of the urgency and danger in each case by the quantity of blood lost and the frequency with which the bleeding occurs. A hæmorrhage of 7, 8 or 10 ounces, recurring at intervals of five or six days or a week, would not be as alarming as hæmorrhage of 8 or 10 oz. recurring every 8 or 12 hours.

Another important point in judging of the advisability of immediate operation is the character of treatment, if any at all, that has been tried.

I am suspicious of copious hæmorrhage 7, 8, 9 or 10 oz., recurring every 8 or 12 hours. After the patient has been put to bed, the stomach emptied by vomiting and all food withheld, together with ice locally, and perhaps morphia hypodermically, a correct decision must depend upon careful correlation of the different factors and individual judgment in each case. I cannot better express my own view than by saying that after two or three large hæmorrhages recurring at intervals of 7, 8 or 12 hours, and after the third or fourth hæmorrhage recurring at intervals of 12 to 24 hours, surgical resources are advisable, are less hazardous, and more conservative than those included under the term "medical." Anything, however, more than a suggestive working rule is impossible at present.

Somewhat more crystalized is opinion regarding the surgical method to be adopted.

The autopsy reports of the Montreal General Hospital show that fatal gastric hæmorrhage takes place under varied conditions. Sometimes the opening in the artery is large enough to admit a silver probe, sometimes water or milk injected into the hepatic artery flowed in a stream into the stomach. In some instances the opening in the artery is in the thickened wall of an old chronic ulcer, not permitting of closure by contraction. In other cases the source of the bleeding could not be found at all.

In the morbid anatomy of the fatal unoperated cases are suggestions as to surgical method. Open the stomach, find the bleeding point and arrest by ligature, cautery, excision or suture, the hæmorrhage, if possible. If the source of the hæmorrhage cannot be found, do as Mr. Moynihan has done with such uniform success, do a gastro-enterostomy. The search for the bleeding point in the first instance is indicated by autopsy findings, and is based on sound surgical principle; and although Mr. Moynihan has not had a recurrence of hæmorrhage after gastro-enterostomy in any of his cases, others have not always been so fortunate, and the reason is apparent.

Chronic Ulceration of the Stomach and Sequelae.

Not less interesting and for the most part satisfactory are the results obtained by surgical methods in the chronic invalidism and indigestion secondary to gastric and duodenal ulceration.

Among the more common sequelae are adhesions and bands; pyloric stenosis and hour-glass contraction. A good example of displacement by a band was seen in a woman transferred from Dr. Finley's ward. There were present a demonstrable dilatation of the stomach, indigestion, pain after eating, and on two occasions a mild degree of jaundice. She was unable to take care of her house and children. An exploratory incision revealed the pylorus hitched up to the neighborhood of the neck of the gall-bladder by a strong thick band 1 inch long and ½ inch wide. When this was divided the pylorus became normally mobile. It was not cicatricial nor narrowed. The symptoms were relieved, and the patient for a year or more, when heard from, was quite well. The band was probably secondary to an ulcer about the lesser curvature, just outside the pyloric ring. Then developed an adhesive peritonitis and later the stretching of the adhesion into a band.

Another most interesting case was that of a young woman in whom there was demonstrable considerable gastric dilatation and indigestion, and imperfect nutrition. A palpable and visible tumour the size of an orange was observed in the pyloric region. It moved up and down during respiration. The diagnosis was gastric dilatation. secondary to gastric ulcer in the neighbourhood of the pylorus, and the accumulation of an unusual quantity of inflammatory and fibrinous tissue.

On opening the abdomen I found that the tumour was a clear, thin walled serous cyst projecting from lower border of liver, and not attached in any way to the stomach or pylorus. The pylorus however was held closely up by short dense adhesions to the under surface of the tumour near the gall-bladder. The cyst was easily enucleated and the pylorus separated and lowered

to its normal position. The opening not being narrowed, no gastro-enterostomy was done. Patient made an uninterrupted recovery.

More frequently the chronic ulceration is followed by the development of a mass of cicatricial tissue that narrows the pyloric opening to the extent of causing an obstruction to the escape of stomach contents, or if situated at a distance from the pylorus, may cause by its contraction and cicatrization, the deformity generally called "hour-glass stomach."

The pyloric stenosis is followed sooner or later by gastrectasis, muscular weakness, motor insufficiency and gastroptosis. A careful analysis of stomach contents is of the greatest value in determining the degree and nature of the altered conditions present. In this group of cases gastro-enterostomy is followed by the most happy and satisfactory results. Patients who have been chronic dyspeptics for years, weak, thin in flesh, living on a spare diet and slops, after the pyloric obstruction is short circuited, gradually increase their diet list, their digestion and assimilation improve, and in a few months have exchanged a condition of chronic invalidism for one of comparative good health. They regain their strength and their weight generally comes up to their old standard.

In this group I have performed when practicable a posterior gastro-enterostomy. The stomach returns to a more nearly normal condition. The gastroptosis and ectasia gradually lessen and sometimes disappear altogether.

The difficulty of determining definitely after the abdomen is opened whether the mass is malignant or benign has been noted by many operators.

In two cases I felt quite sure that I had to deal with an inoperable carcinoma. The masses were so hard there was visible such a degree of puckering and the glandular involvement so general that gastro-enterostomy was performed under the impression that it was the only thing possible. In one of these cases four, and in the other two years have passed, and they are still in perfect health. The question of malignancy has been eliminated by time.

A most interesting condition was found in the case of an old man 75 years of age, referred to me by Dr. Lafleur. A man of large frame, his general appearance as he walked in was good. His stomach was largely dilated, its outline visible on inspection. There was no mass to be felt. He said that he had vomited almost everything taken during the past week, the vomitus on one occasion containing food taken 36 hours before. Hydrochloric acid was present in normal quantity; lactic acid was also present. The diagnosis was pyloric ulcer, probably benign with cicatricial narrowing. I found a very small hard contracted pylorus.

The opening seemed to be almost occluded. The pylorus was altogether, I think, a third less in size than the normal. Several isolated glands in the gastro-hepatic and gastro-colic omenta were enlarged.

The question of malignancy was here of the utmost importance. If malignant the condition was early and suitable for a radical operation. If benign a gastro-enterostomy would be sufficient and much safer. I decided to regard it as malignant because of the narrowing and contracting of the pylorus as a whole. In the simple ulcerations I have found the pylorus normal in size, or thickened locally or enlarged to variable sizes by the building up of fibrous tissue. The man's age was that at which we look for malignant growth. I excised 12 inches of duodenum together with about 6 inches of the stomach, closed the stomach and inserted the cut end of the duodenum into a new opening made for the purpose in the posterior wall. The man made a very smooth recovery. There was no vomiting, and when he left the hospital he was on full diet, eating three good meals a day. Now the point in this case of greatest interest is the pathologist's report. He found the hard cicatricial mass malignant, and in the excised portion of the stomach near the pylorus were 6 or 8 simple gastric ulcers. It seems fair to assume that in this specimen we have an instance of a benign gastric ulcer changing its character and becoming malignant. When last heard from about a year after operation the man was quite well.

Gastric Syphilis.

Gastric syphilis is a rare condition and its diagnosis exceeding difficult, possibly always doubtful. The following case is of exceptional interest because it was observed intra-vitam and because the patient made a perfect and lasting recovery.

The man was thirty-nine years of age, single and had indisputable clinical evidence of antecedent luetic infection.

The case was reported before Association of American Physicians by Dr. Lafleur, with whom I saw the case several times before operating. For a full report I refer you to the "Transactions of the Association of American Physicians," and will give you only a synopsis of the findings. Operation was undertaken for the relief of gastric distress, nausea, occasional vomiting and diarrhœa, not alleviated by restriction of diet, lavage or drugs.

The stomach wall was thick, about 1 cm., in places 1½; very little bleeding, muscular tissue showed complete denudation of the mucosa over an area extending completely around the stomach at the pyloric end of the incision. The same condition extended along the interior and anterior aspect of the stomach toward the cardiac end of the organ fully four inches. Here and there, especially toward the

margin of the bared surface, there were small islets of mucous membrane having a rough cockscomb appearance and a purplish tint. The edges of the ulcerated area were well defined, sharp in outline and abrupt. The edge was slightly heaped up and undermined and just in the undermining angle was a whitish line. The surface of the ulcerated and denuded area was rather smooth (neither caseous nor necrosing) of a pinkish red colour and almost bloodless. In the thickened area some cicatrization and contracture had occurred, producing a certain degree of hour-glass contracture, two or three inches from the pylorus. A slice of mucous membrane, a section through the muscular wall and mucosa and a snipping from the edge of the ulcer were taken for microscopical examination. After extending the wound to give sufficient space the exuberant edges of the ulcer were pared, the base was curetted, and the thermo-cautery lightly applied to as much of the ulcerated surface as could be reached, the very slight bleeding following curettage being easily checked by the same means. The gastric and abdominal wounds were then closed by suture.

The tissues removed were examined by Dr. P. G. Wooley, who reported as follows: "The tissue from the base suggested malignancy, for there were small masses of epithelial cells surrounded by a fibrous stroma; but the edges of the ulcer were simply fibrous tissue and muscle, the former in excess, and there was no marked infiltration. The base was markedly inflammatory and not malignant."

That the condition was not one of *ulcus simplex* of unusual dimensions such as have been reported in medical literature from time to time may be difficult to prove. Dr. Lafleur, however, reports that the man was not a chronic dyspetic and that anacidity and not hyperacidity existed from the onset of the illness. The chief argument is drawn from the anatomic character of the lesion. Histologically the tissue removed bore a close resemblance to those in the case reported by Dr. Flaxner as gastric syphilis, in Vol. x., 111, of the "Transactions of the Association of American Physicians."

It is over three years since the operation was performed. During this period he has been in perfect health, weight up to his standard and no indigestion.

This diagram is intended to show you the result of ulcer of the posterior wall of the stomach with adhesion of the duodenum.

The patient, a male, aet. 53, was transferred from Dr. Finley's ward in the Montreal General Hospital on the 25th of February, '05. His stomach symptoms began 10 years before. The pain and vomiting after meals had gradually increased in frequency and severity. During the past year vomiting would occur almost daily for weeks at a

time. He never vomited blood. During the past 14 years has lost 51 lbs. in weight, 25 of which were lost during the past year. Has occasionally suffered from what he calls distension, which would be somewhat relieved by belching gas.

Heart normal, pulse regular and of low tension; arteries palpable and sclerosed.

Blood exam.—Red cells . 5,810,000
White. . . . 12,800
Hæmoglobin. 65

Examination of stomach contents after a test meal: no free HCl., lactic and butyric present and retention of solids and fluids.

Right kidney freely moveable and easily palpated.

On opening the abdomen I at first thought that I had to deal with an hour-glass stomach. On examination I found, however, that the central constriction was the pylorus considerably dilated, and that distal to the pylorus was the duodenum dilated to fully the size of a normal transverse colon. Below the meso-colon the jejunum appeared normal. Nothing unusual could be seen or felt on the anterior wall of the stomach, but on depressing the anterior wall I came upon a deep, cup-like, round, smooth depression on the posterior wall, into which I could easily insert the end of my thumb. It was the size of a child's little teacup. It lay apparently right over the aorta. An obstruction at the end of the third or fourth part of the duodenum was evident. That the obstruction was due to the involvement of the duodenum in the mass of cicatricial tissue behind the stomach and secondary to hepatic ulcer seemed equally obvious. The remedy clearly lay in a gastro-jejunostomy. I opened the meso-colon but found that so nearly the whole posterior wall of the stomach was involved in the cicatricial mass that a posterior gastro-enterostomy was out of the question. I therefore closed the opening in the meso-colon and did an anterior gastro-jejunostomy and an entero-enterostomy. The patient made a perfect recovery. He left the hospital on the 24th May, having gained 34 lbs. in weight since the operation. He could take full meals without any pain, nausea or distress. An enlarged mesenteric gland removed for examination showed very slight inflammatory change, and no evidence of malignancy.

These different groups of cases illustrate the variety of benign lesions requiring surgical relief, and the variety of surgical procedure indicated.

There was no death in the series.

THE TREATMENT OF CYSTITIS.*

By H. A. KELLY, M. D.

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(Continued from our last issue.)

SURGICAL TREATMENT OF CYSTITIS.—It is in the surgical treatment of cystitis that the greatest difference is found between our practice and that of our immediate predecessors of even a decade ago. And it is here that I have some fresh additions to make, bringing some utterly rebellious cases entirely within the scope of successful treatment.

There are two kinds of surgery, minor and major.

Minor cystic surgery consists in the use of a sharp or serrated curette, or a wire brush, or of a bunch of fine wire needles. I expected great help from these instruments when I began to use them, but must confess to disappointment in the issue. The tissue removed is of value in differentiating a tubercular bladder, but I cannot see that the treatment is hastened, while harm may be done, as Sampson has shown if the ureteral orifices are injured, favoring an ascending infection.

Major Surgery. When I receive a case of intense vesical inflammation, where all local treatments, even the mildest, are impossible on account of the pain produced, I, without loss of time, resort to major surgery, and propose at the outset to put the bladder at rest by making the Parker-Emmet incision in order to secure good continuous drainage. I do this in a few seconds, often by putting the patient in the knee-chest posture and letting air into the bladder through the urethra. Then lifting up the perineum the anterior vaginal wall is exposed and lifted a little on a pair of curved artery forceps slightly opened. A knife is plunged through the septum at this point and the opening enlarged fore and aft until it is at least an inch long. I wipe out the bladder thoroughly with dry gauze and sew the vesical mucosa to the vaginal at about six points to prevent too rapid closure of the wound. All this takes about the same time to do it that it does to describe the operation.

Such an opening ought to be left, as a rule, for from three to six months. The bladder and vagina should be irrigated every day, either *per urethram* if not too sensitive, or *per vaginam*. A continuous daily hot water bath

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as recommended by Hunner, leaving the patient immersed for hours, is a most valuable adjuvant in the worst cases. In due time the bladder will be found to have cleared up, perhaps wholly, when the fistula is closed and the patient discharged. On the other hand many cases clear up only to a certain point, and go no further, and of these I wish to speak somewhat particularly, for this is that large residual group of our worst cases of cystitis, generally looked upon as hopeless.

Let me briefly outline the treatment of such a case. In the first place, given one of these intensely inflamed old cases of cystitis in a patient worn out with vigils and suffering, mild courses of treatment are worse than useless, serving only to increase the distress. To avoid discouragement, tell the patient, who has suffered for years, that she must be content to give a few months or perhaps a year or more to getting well. Then begin by opening and draining the bladder, then when you find the organ cleared up to one spot you may try for a few weeks to heal that by direct applications of nitrate of silver or argyrol, and in this you may succeed. If you fail and there is a tendency to relapse, make a suprapubic opening and cut out a crescentic piece, including the entire thickness of the bladder wall, and sew it up with catgut suture on the inside and fine silk on the outer surface.

If you have to open the peritoneal cavity, and the bladder is a foul one, you can sequestrate the entire vesical region by suturing the round ligaments and the uterus to the abdominal wall from side to side, converting the peritoneal cavity behind the symphysis into a closed pouch, which is then drained over the symphysis. In a bad case which I treated in this way and had to open later for an ovarian trouble, there was no trace of the pouch left.

I have not found great help from the making of a small suprapubic opening in association with a vaginal opening for through and through drainage. If, however, worst comes to worst, I would make a big suprapubic opening, partially detach the recti, and put the patient in a hot tub for as many hours daily as she could stand.

I. Mrs. R., age 55, came to me in October, 1899, with a chronic cystitis which had persisted for fourteen years in spite of being several times "cured." I found the entire vesical mucosa covered with scattered foci of ulceration pouring out a curdy pus. The urine was alkaline, containing a short organism, probably the colon bacillus.

She received under my care the following treatments: A borax and soda solution by irrigations, applications of the nitrate of silver (2—4 p. c.), insuffiations of boric acid powder against the diseased

vesical wall, formalin irrigations (1—15,000 to 1—2,000), irrigations of silver nitrate from 1 to ½ p. c. strength.

Under these treatments there was a steady improvement, the organisms decreased, and the capacity of the bladder increased from 60 to 280 cc. She was cured in 41 days and has remained well ever since. I tested the efficiency of the treatment by making cultures on several successive occasions and noting that there was no growth. So since this cure there has been no relapse.

Let me illustrate the group of difficult cases by giving you a brief outline history of seven of my patients. In two the disease was tuberculosis, in the others the organism was a colon bacillus.

II. Miss J. MacD., 33 years of age, came to me in 1899 suffering from frequent urinations with a slight pyuria and hematuria.

Examination showed an area of intense cystitis at the vesical vertex, and as she had suffered for four years I proceeded at once to surgery and opened the abdomen and excised an ulcerated area of the bladder at the vertex 3 x 2½ x 1½ cm. in size. This was closed without drainage, using sixteen catgut sutures in the first and ten in the second layer. She recovered at once and has been in the best of health ever since.

The pathological examination of the greatly hypertrophied bladder wall showed granulation tissue and inflammatory infiltration.

III. Miss J. R., age 29, came to me in March, 1900. She had been suffering with her bladder for five years. It is probable that the frightful cystitis from which she suffered was induced by catheterization in a hyperacid bladder in a nervous woman.

She was in a wretched mental state from the suffering night and day, emptying her bladder every few minutes.

The urine was full of pus and contained blood; cultures showed that the infectious organism was the colon bacillus.

Cystoscopically, the bladder was of an intense angry red color, with extensive areas of ulceration; there was not even a small area of sound tissue seen at any point. She simply screamed whenever she was touched.

She was about three years under treatment, and her recovery is largely due to the untiring efforts of my chief nurse.

The following treatments were used:—

1. Curettage and the use of the wire brush over the whole inner surface of the bladder, followed by a 10 p. c. solution of silver nitrate.

2. Fourteen days later another curettage.

3. Ten days later I was able to catheterize the left kidney and demonstrate a left pyonephrosis, which was opened and drained. At the same time a suprapubic cystotomy was done to facilitate irrigating the sensitive bladder.

I left a mushroom catheter in the kidney wound and a ureteral catheter in the ureter to facilitate washing out the kidney.

4. Dilatation of the renal and suprapubic openings.

5. Left nephrectomy (intra-capsular enucleation) by morcellation. Closure of the suprapubic opening.

6. Plastic operation narrowing the urethra, which had been over-stretched before she came to me.

7. Plastic operation repeated.

The bladder was so small when I began to treat her that she could not hold as much as 10 c.c. of fluid, and even under extreme anesthesia she strained and forced the fluid out of it more was thrown in.

During all the time of the above treatments she received at Miss Cook's hands 135 irrigations of either boric acid or nitrate of silver with boric acid.

Under this regimen the bladder recovered its capacity and normal appearance. To-day she is in perfect health and suffers no pain. The only remaining discomfort is that she urinates often, and this I have been unable to overcome, although I can now put 400 c.c. into her bladder.

IV. Miss C. P., age 52, came to me in October, 1902. I saw her first in bed, a lifeless invalid, suffering intense pain, with spasmodic exacerbations day and night. I never saw a sadder picture. She lay in a constant state of apprehension of pain and screamed when the vagina was touched even for the purpose of making the gentlest examination. The entire bladder was the seat of intense inflammation and ulcerations from the vertex to the left ureter. Its capacity was two-thirds of an ounce (20 c.c.).

She has made a perfect recovery and has remained well under the following treatments:—

1. October, 1902, vesico-vaginal fistula for drainage.

2. November, 1902, suprapubic fistula to wash through and through; enlargement of vesico-vaginal fistula. Plastic operation, opening the vulvar orifice, which acted like a sphincter to retain the foul urine in the vagina and bladder.

3. January, 1903, dilatation of suprapubic fistula with Hegar's dilators and introduction of a self-retaining catheter.

4. February, 1903, left nephroureterectomy, removing a tubercular kidney and ureter.

5. April, 1903, closure of the vesico-vaginal fistula.

Irrigations of a half saturated solution of boric acid were given from one to six hours daily, amounting in all to 1,000 hours of treatment.

The result has been an absolute recovery, and she is now stout, robust, and able to attend to all her household duties in town and country.

V. Miss L. M., aged 24, came to me in January, 1900. She had

had a vesico-vaginal fistula made to drain an intensely inflamed bladder three years before.

After trying various palliative measures, I opened the bladder above the pubis and trimmed off numerous granulations from the posterior vesical wall and then drained the bladder with iodoform gauze.

In November, 1902, I excised the entire diseased area, including all the bladder wall, removing a triangular area from the vertex to the base of the bladder 1 cm. in thickness, and closing the opening with interrupted catgut sutures tied within the bladder. This is the case in which the whole bladder area was excluded from the peritoneal cavity by sewing the rouud ligaments and fundus of the uterus to the anterior abdominal wall. (See Johns Hopk. Bul., 1903, p. 96.)

All of the disease was not removed at this time and I had subsequently, on account of repeated hemorrhages, to open the bladder again (November, 1903,) and excise three pieces, one in front, one at the vertex and one at the posterior wall.

The wounds were again closed with interrupted catgut sutures tied on the inside of the bladder. It was wonderful to see how little traces were left of the sequestration operation; there were only a few adhesions between the bladder and tubes and ovaries.

Remarkable features in this case were, first, the fact that giant cells were found in the tissues excised when we had been utterly unable to discover any bacilli in the urine or curettages, examined repeatedly over periods of months' duration.

Second, that the disease was primary, as far as the urinary organs were concerned, in the bladder, there being no renal disease.

VII. Mrs. H. M., age 34, came to me in May, 1901. She was an utter wreck from nine years of suffering, extremely emaciated, and abandoned to die of an advanced tuberculosis of both kidneys and bladder. The bladder was ulcerated from vertex to urethral orifice and there was not a sound spot to be seen.

I began, May 4th, by draining the bladder by the vagina and giving rest from the constant suffering.

May 18, a left nephrotomy was done.

June 15, left nephrectomy and a ureterectomy as far as the pelvic brim.

October 14, closure of the vesico-vaginal fistula.

October 22, 1902, extirpation of the lower end of the ureter.

Feb. 3, 1903, re-establishment of vesico-vaginal fistula and curettage of bladder.

February 24, 1903, suprapubic resection of the bladder, taking away about one-half of the bladder, including the left ureteral orifice.

April 9th, 1903, closure of the vesico-vaginal fistula.

With these surgical measures were associated irrigation and distention treatments, as well as topical treatments with silver nitrate.

From holding nothing at all the bladder has increased to normal capacity in spite of the extensive resection done; in October, 1903, it held 225 c.c.

She is now practically a well woman, stout, hearty, and attending to all manner of household and social duties.

I trust, in conclusion, gentlemen, that I have demonstrated that, granted the important elements, skill and patience, practically all cases of cystitis, even the worst, can be cured.

The first step is to make a correct diagnosis, so as not to treat as a cystitis a case of irritable bladder.

The next step is to determine the grade of the disease and the character af the infection, and, most important, to differentiate tuberculosis.

Again, the kidney must be borne in mind as a possible source of reinfection in cases very slow to clear up.

After a thorough study of the field begins an aggressive campaign on the lines indicated, well defined and progressive until the patient is cured.

THE BURIED SUTURE.*

By J. M. ELDER, B. A., M. D.,

Attending Surgeon to the General Hospital; Assistant Professor of Surgery, McGill University, Montreal.

BURIED sutures are to-day so much a part of every major surgical operation, that a discussion as to the best material to be employed in any given case, cannot fail to be of interest to the general surgeon and practitioner. The following questions are always meeting us: What is the best suture material, and how best to prepare that material to insure first of all its asepsis, and second that we may rely upon it to last as long as it may be required. Apart from the essential condition of securing asepsis, the material will, of course, differ for different tissues, it being quite clear that materials suitable for suturing soft tissues may not be so suitable for tendons or bones. The buried sutures hitherto used in surgery may be roughly divided into main classes: First, absorbable; second, non-absorbable. The former is the ideal suture. A material that will hold the tissues together until such time as nature has firmly united what the surgeon wishes to remain united, and then efface itself by absorption, is exactly what the surgeon wants. But just here is the difficulty. How are you to gauge the length of time it will take any given suture to become absorbed? And even if you do that, how are you to know that the parts will have sufficiently united to do without the suture? The difference in time which wounds in different individuals take to heal is notorious. An incision in one patient will be healed in four days, while in another a similar incision will not be healed in ten. Hence, at times, we must use non-absorbable sutures.

But another consideration which, at times, predisposes us to the non-absorbable sutures is that the absorbable suture when buried in living tissue is always liable to stretch more or less, and thus to allow the parts to separate which it is supposed to hold together. It is for this reason, doubtless, that the majority of operators to-day prefer a non-absorbable suture, such as silk or linen, in intestinal anastomosis, where catgut, by stretching, might give serious results.

In the non-absorbable suture we use some material, (for example, silk or linen thread) which would be soft and pliable, work easily, and be of such strength that a fine strand could be used, and which would rapidly become encysted and give no further trouble. That is

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* Read at Meeting of the Canadian Medical Association, held at Halifax, August 22nd, 1905.

what we expect of all non-absorbable buried sutures, viz., that they will become encysted, just as we expect the absorbable ones to disappear entirely.

In dealing with bones and other tissues requiring material of greater strength than either silk or linen thread, we use malleable metal wire of different sizes to suit the work we need. I shall later refer to wire sutures more fully.

Let us look at these classes of sutures somewhat in detail, in order, if possible, to obtain some practical rules as to which would be best in any given case.

First, the *absorbable* buried sutures. Here we have to deal with such substances as catgut, kangaroo tendon, and other animal preparations. The difficulty at first was to get a sterilized product. That difficulty has now been overcome, and to-day every hospital of any size is able to procure for the surgeon's use perfectly reliable sterile catgut, and the general practitioner can always procure from reputable makers an equally reliable material of any desired size, put up in closed tubes, preserved either in alcohol or chloroform. A mistake, I think, we first made with catgut was that we used the strands too large—we left too much material to be absorbed; there was a gelatin deposit there—an admirable culture medium—and we frequently got mural abscesses as a result. This led to the German surgeon's dictum of a few years ago: "Auf mit dem catgut". The tendency now is to use the finest strands that will do the work, and not the huge coarse catgut of bygone days, used simply because it was sterile. But all catgut when wet, as it is when it is put in the tissues, stretches; and moreover we were not quite sure, in any given tissue, just how long exactly that catgut would last. Hence the demand came for a catgut that could be relied upon to remain insoluble for a certain period of days, and further that we might safely vary the number of these days.

This has been accomplished by treating the sterilized catgut with chromic acid—the "chromicised gut" of to-day—which may be procured in tubes just as the plain catgut may. So that we can now prepare or obtain chromicised catgut of different sizes which will last for fifteen days, or even a month. I think nothing has given such an impetus to the use of absorbable buried sutures as this improvement in the preparation of catgut. The first chromicised gut we had was not sufficiently pliable, it was brittle and liable to break, hard to thread in the eye of the needle, and difficult altogether to work with. This has now been completely overcome, and chromicised catgut may be prepared, or bought, under the same conditions as ordinary plain catgut. For the benefit of those who may wish to prepare it themselves I give herewith our method of preparing both

plain and chromic gut at the Montreal General Hospital, and I venture to say that from neither of them, during the past two years, have we had any septic condition in any way fairly attributable to the suture material. Frequent bacteriological control tests are made, in addition to the test for each lot before any of it is used.

"Juniper Oil" Catgut.

Catgut is cut in lengths of 60 inches and made into coils.

Catgut Nos. 1, 2, 3, 4, is placed in a jar containing juniper oil for eight days. This renders it more pliable when kept. Heavier numbers from 12 to 14 days.

It is then transferred to alcohol for 48 hours and stored in sublimated alcohol 1-500.

Catgut is ready for use in 5 to 7 days thereafter.

Chromicised Catgut.

Catgut is cut in lengths of 60 inches, washed with castile soap and water, wound on glass reels, and placed in a jar, containing a liberal quantity of 1% chromic acid for 9 hours.

Cover the jar with a piece of gauze, pour off the chromic acid, and replace by sulphurous acid (B. P.) for 12 hours.

Again cover the jar with gauze, pour off the sulphurous acid, and cover the catgut with 2% sol. of salicylated alcohol.

Stopper loosely and boil in a water bath for fifteen minutes, then cover tightly and leave for two weeks, when cultures are taken. If sterile, it is ready for use. This gut will last for 21 days before absorption affects it.

The heavier the catgut the more difficult it is to prepare, and the greater the length of time in solution.

Kangaroo tendon was formerly used when we wished a suture which would last for a long time and still be strong, as in radical cure of hernia, but the recent improvements in the preparation of chromicised catgut have, with us, at least, largely if not entirely, displaced it.

Now as to *non-absorbable* sutures. Here we have a choice as regards plastic work, between silk and linen thread of different strengths, the latter either plain, or treated by the celluloid process of Pagenstacher. Many good surgeons to-day use this material. They say it has all the advantages of catgut and none of its disadvantages; that no harm comes from any number of buried sutures or ligatures of either silk or linen thread; that it is much easier to prepare, easier boiled or sterilized; and that you can always sterilize it just before you want it. It has the great advantage over catgut that it never stretches, thereby allowing the parts to separate before healing has quite taken place. Unquestionably it is displacing catgut as a suture material where we wish to approximate serous surfaces, as for example, in the

peritoneum. I think any one would feel very much safer with a good silk or linen thread suture, which could be very small in size, to approximate peritoneal surfaces, in intestinal or gastric work, and for that class of work it leaves nothing to be desired. I am not so clear, however, that in operating upon other tissues, for example, muscles, or other subcutaneous structures, where one has to leave in a multiplicity of ligatures and sutures, that it is desirable to have a large number of small cysts enclosing the suture material, when we might, and do, get as good results from a material which does its work and disappears. I think the ideal method here is still the better.

Further, in intestinal anastomosis the practice of the present day appears to be rather towards using catgut to approximate the raw surfaces, which material will afterwards dissolve and discharge into the lumen of the gut, and then to use silk or linen thread for the reinforcing Lembert sutures. Undoubtedly, though, good surgeons use catgut altogether for both, and equally good surgeons, but certainly more of them, use silk or linen thread for both. Silk or good linen thread is undoubtedly to be preferred by the general practitioner who has to prepare his suture material for some surgical emergency to be treated in the country or in a private house. The whole of the needles and the silk or the linen can be thoroughly boiled together, and one is quite sure then that he is using aseptic material.

Silk worm gut is another form of non-absorbable material which for many years held its own as a buried suture, especially amongst our friends the gynæcologists. It does so yet, I doubt not, in some places; but I fancy that the general trend is to discontinue its use as a buried suture, though as a skin suture it leaves little to be desired. The disadvantages of it were that the ends of the knot, cut them short as you might, were liable to irritate, especially if put in any place near moving tissue, and the result of that irritation, sooner or later, was the breaking down of the encysting capsule and the formation of an abscess at that point, leaving a small sinus which would not heal up until the removal of the offending material. I myself have several times removed silk worm sutures several years after they had been placed in position, and thus cured a sinus which would not heal otherwise.

Silver wire, if well buried, and not exposed to movements by the surrounding tissues, forms an admirable suture. That silver has any antiseptic properties in itself, which renders the track of the suture less liable to infection than in the case of other materials, I do not believe. I find, for example, that the use of broom wire, which I have now been using for nearly

two years, as a buried suture in bone surgery, instead of silver wire, which I formerly had used, is attended by equally good results, and broom wire, apart from its cost, has many physical properties which make it much preferable to silver wire. For example, it is stronger, more pliable, less brittle and the knot more easily and thoroughly embedded at the site of the suture. These metal sutures may be easily and quickly sterilized by boiling or by passing through the flame of the spirit lamp just before using. They should never, in any case, be passed completely around the bone which one purposes holding together. Just as reasonably may you put a wire round the bark of the trunk of a tree and expect that the tree will survive if the wire holds—the circulation is cut off and the tree will die. So is it with periosteum and bone.

Now, what conclusions may we fairly draw as a result of what I have said? That every one at this meeting will agree with all I have said, I do not for a moment suppose; but my conclusions are that for sutures where we may expect union in five days or a week, I should prefer plain catgut, except in the gastro-intestinal tract: there I should prefer silk or linen thread, and I have no preference for one over the other. I prefer this because I feel that it will not stretch, that it is strong enough to stay where it is put, and with the plastic material at your disposal in the serous surface of the peritoneum, one is sure that there is plenty of encysting material present and that the suture will give no further trouble. It is so essential here that the parts should remain in accurate apposition. I see no especial benefit to be derived from Pagenstacher's celluloid linen thread.

For buried sutures which require to remain in place longer than a week, I should use some of the forms of chromicised catgut, erring on the safe side as regards the length of time they are supposed to last, and in all cases using no heavier gut than will serve my purpose and stand the strain likely to be thrown upon it. For tendon sutures, I would use chromicised catgut or silk, whichever would best do the work; and for bone sutures, as I said before, I prefer the use of ordinary broom wire, which does not rust and which may be procured in the different strengths of silver wire and can be used very much smaller in size than the latter and still give the same strength. The end of the twisted wire can be most carefully clipped off and hammered smooth, covered with periosteum where possible, or hammered well down into the bone if that be impossible, so that the muscles may play over a smooth surface, and not be irritated, thereby predisposing to abscess formation.

Silk worm gut, as a buried suture, I can see no future for, though it has a past. Horsehair has been—and is still used—as a buried suture, and so far as I know nothing can be urged against it. Two years ago I saw Sir Victor Horsley using it entirely as suture and ligature material in his well-known operations upon the skull and scalp.

CASE OF HERPES ZOSTER OPHTHALMICUS

By T. C. LOCKWOOD, M. D.,

Lockeport, N. S.

NOTICING an account of a case of Ophthalmic zona in the *Medical Bulletin* taken from the "*Recueil D'ophtalmologie*" has reminded me of a somewhat similar case occurring in my own practice.

A strong man of fifty years, who had, however, been feeling indisposed for three months, was suddenly seized with an intense right supra-orbital neuralgia and in the course of about forty-eight hours there appeared an herpetic eruption of a very severe character, implicating the right side of forehead to the median line and into the hairy scalp. The right side of the nose and right infra-orbital region were also implicated but not so severely, the whole affected area corresponding to the cutaneous distribution of the ophthalmic division of the fifth nerve. The patient's temperature was now 98.5 F. and pulse 62; there was very severe nocturnal pain and some mental depression. The next day I found the eruption had assumed an erysipelatous appearance. The lids of right eye were much swollen, and conjunctivæ injected, with a profuse purulent discharge. There was pronounced photophobia, and the cornea showed one small area of infiltration and was anæsthetic. The pupil was slightly dilated. The iris was not inflamed. The tension of eye was normal or slightly decreased. The acuity of vision was impaired to a considerable extent. The temperature was still normal.

At this stage of the disease the pain subsided to a large degree, but noctural neuralgia was felt for some weeks, by which time the vesicular lesions were well healed, leaving, however, large cicatrices. The eye symptoms also rapidly abated, and with the exception of a small more or less permanent area of a corneal opacity and a slight drooping of the upper lid due to tarsal hypertrophy, the result of inflammation, the organ has returned to its normal appearance. There is now present, however, a condition unusual in this disease, namely, a troublesome binocular diplopia caused by insufficiency of the right external rectus.

There are recorded cases of inflammation of the third nerve, and also atrophy of the optic nerve in ophthalmic zona (see "Nettleship"). The inflammation of cornea, iris and choroid is explained by the fact that the sensitive nerves of these tissues are derived from the nasal branch of the fifth nerve. The complication of other nerves in these cases may often help in determining the seat of the lesion. Inflammation of the Casserian ganglion was found in the only case in which a post mortem examination was made during the acute stage of the disease.

Although there was no sign of acquired syphilis, this case was treated with gr. iii. doses of pot. iod. given every four hours during the first week and then three times a day during the following three weeks. The herpes was annointed with 25 per cent. ichthyol ointment, and the eye was kept clean by warm boric solution frequently applied. Atropine was instilled only twice. Quinia and acetaniled were given with good effect for the nocturnal pain

I have thought the case worthy of recording, as I think this disease is comparatively rare in Nova Scotia at least.

SOCIETY MEETINGS.

A REGULAR fortnightly meeting of the Halifax and Nova Scotia Branch, British Medical Association, was held on Dec. 6th, 1905, at the City Council Chamber, the President occupying the chair.

Dr. D. G. J. Campbell, on behalf of the Staff of the Halifax Visiting Dispensary, brought to the notice of the Branch the case of an infant suffering from gonorrhœal ophthalmia, which had been refused admission into the Victoria General Hospital, by virtue of the by-law excluding children under six years ago. It was resolved that a committee of eight be appointed to consider the whole question of hospital accommodation.

At the conclusion of the business, Dr. R. Evatt Mathers read a paper entitled "Acute Otitis Media and its Treatment" (To be published in a future number).

Dr. Kirkpatrick in discussing the paper, pointed out a few rules for the guidance of the general practitioner in the treatment of otitis or otalgia from any cause. An attempt should always be made to abort these attacks by rest in bed, catharsis, local depletion and hot applications, and an opiate if necessary, or two or three drops of a 5% solution of cocaine followed by adrenalin.

When the discharge appears, frequent cleansing with 1 in 8000 bichloride solution is indicated. Dr. Kirkpatrick condemned the use of cotton wool plugs in the external auditory canal. He considered instillation to be indicated only after the febrile stage, and recommended a combination of boric acid and alcohol as one of the best.

Drs. Farrell, C. D. Murray and King also took part in the discussion which was concluded by Dr. Mathers.

Dr. Goodwin read some notes on "The Flavoring of Medicines." He first considered the various forms of syrups. In cases where there is objection to its action on the stomach or liver he recommended glycerin or honey as substitutes. Other excellent flavorings were the elixirs of the U. S. P., licorice and the various aquæ, especially chloroform water. Nearly all of the members present took part in the discussion of Dr. Goodwin's paper, after which the meeting adjourned.

On December 20th, 1905, the Branch met again at the City Council Chamber in regular fortnightly session, the Vice-President, Dr. James Ross, being in the chair. After routine business, Dr. D. A. Campbell read a paper on "Aortic Regurgitation," (to be published later.)

Dr. Stewart in discussing the paper, referred to aortic regurgitation as the most interesting of heart lessons. He thought that there were many undiscovered cases which were responsible for much ill health; and that strain was one of the chief causes, especially in young athletes undergoing hard training. Dr. Stewart clearly recalled how Balfour of Edinburgh had so strongly insisted upon the recumbent position

in these cases, and on large doses of digitalis, the tincture being the favored preparation.

Dr. Chisholm cited two or three cases of his own in which sudden death had occurred during the exhibition of digitalis. As a substitute for digitalis he found convallaria useful, or a blue pill every second night, together with morphine.

Drs. Eagar and Trenaman also took part in the discussion.

Dr. Campbell in conclusion said that sudden death was often to be expected in aortic regurgitation, independently of medicines used. He agreed with Dr. Eagar that exact diagnosis in valvular disease is difficult and often unnecessary. He considered that the special preparation of digitalis used was of little importance, the essential point being that the drug should be good. The most active form is that obtained from the stem leaves of the indigenous plant in the second year of its growth.

Dr. Robert King read a paper on "Lobar Pneumonia," which he explained, was an analysis of 282 cases seen at the Royal Victoria Hospital, Montreal, with frequent references and comparisons to another series of 486 cases at the Montreal General Hospital, compiled by Dr. MacRae and others.

Dr. L. M. Murray spoke of the large number of immigrants with the disease who came from every immigrant ship into the Montreal General Hospital. He had noticed that the mortality varied a great deal with the different groups. He said that the serum treatment for pneumonia had so far been successful only with laboratory animals.

Dr. D. A. Campbell gave it as his impression that lobar pneumonia was a comparatively rare disease in Halifax, pleurlsy with effusion being far more common. The months of April and May were the worst months for pneumonia in Halifax, the broken weather of the fall months also showing many cases. He thought that the death rate varied with the size of the city, that of Halifax not being much over 15%.

Drs. Chisholm, Doyle, Trenaman, Eagar and A. P. Reid also spoke to the subject of the paper.

Dr. A. P. Reid addressed the Branch concerning the Health Act of Nova Scotia, which, he said, did not give the Provincial or other health officers sufficient powers for inspection of dairies, slaughter houses, etc. He asked for advice and assistance from the Branch in his endeavor to secure a better arrangement. A committee was appointed to confer with him.

After adjournment, Dr. Campbell showed some interesting post mortem specimens, illustrating his paper.

The Branch met on January 3rd at the Queen Hotel.

Dr. S. A. Fulton, of Truro, was duly elected to membership.

It was resolved that the Branch concur in the invitation sent on behalf of the Government to the American Medico-Psychological Association to hold its next annual meeting at Halifax.

After other business the President introduced Dr. Wm. Rockwell, of

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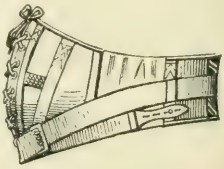

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River Hebert, who read a most interesting and carefully prepared case report and paper on "Sub-Diaphragmatic Abscess following Operation for Appendicitis," which will be published later.

Dr. Stewart discussed the paper at length, being followed by Drs. Murphy, G. M. Campbell, King and others.

Dr. Trenaman moved a cordial vote of thanks to Dr. Rockwell. This was seconded by Dr. Morton. Carried, and presented by the President, after which the meeting adjourned.

OBITUARY.

DR. J. F. BRINE.—The death of Dr. John F. Brine, of Canso, occurred on the 18th inst., after an illness of some months. He was a son of Rev. R. F. Brine, and was born at Arichat, where his father was rector of the Anglican church for a number of years. Dr. Brine was a graduate of Harvard University, and was a classmate of Sir Louis Davis and Sir Frederick Borden. He practiced his profession at Charlottetown and Souris, removing from there to Richibucto. About fifteen years ago Dr. Brine removed to Canso, having been appointed medical officer to the staff of the Commercial Cable Company, Hazel Hill. He enjoyed a large practice in the town and also held the position of port physician. He leaves a widow, who was a Miss Sterns, of Souris, and four children—Mrs. Demont, of Hazel Hill; Harry F., of Charlottetown; Frank, in the employ of the Eastern Townships Bank at Sherbrooke, Que., and William, on the staff of the Commercial Cable Company, Hazel Hill. Dr. Brine was a member of the Masonic order, and the funeral was conducted by members of the order.

DR. WM. M. CAMERON.—The sudden death of Dr. Wm. M. Cameron of this city occurred at his residence on the evening of the 24th inst., in the 63rd year of his age. The deceased was a native of Pictou County, but came to Halifax when a young man and joined the police force. He finally left the force to study medicine, and went to the office of Dr. Parker. He studied at the Halifax Medical College, afterwards at the College of Physicians and Surgeons, New York, from which he graduated.

For many years Dr. Cameron enjoyed a large and lucrative practice, and he was always ready to attend the poor as well as the rich. A few years ago, however, his health obliged him to relinquish considerably the active duties of a busy practitioner. He married Miss Oxley, a daughter of William Oxley, of Oxford, who with two sons and one daughter survive.

The NEWS extends its sincere sympathy to the bereaved relatives.

CURRENT MEDICAL LITERATURE.

THE NEUROTIC DISORDERS OF CHILDHOOD, including a study of auto and intestinal intoxication, chronic anæmia, fever, eclampsia, epilepsy, migraine, chorea, hysteria, asthma, etc. By B. K. RACHFORD, M. D., Professor of Diseases of Children in the Medical College of Ohio, etc., etc., etc. Price $2.75. Published by E. B. Treat & Co., 241-243 West 23rd street, New York.

For fifteen years or more Dr. Rachford has been familiar to readers of current medical literature as a persistent and insistent advocate of the causal relationship between autotoxis and various morbid conditions. His articles have been characterized by a clearly stated application of the teachings of the Bouchard school to the practice of medicine. A revision of a series of papers on physiological factors of the neuroses of childhood, in which the physiological peculiarities of the immature nervous systems of infants and children are considered in their bearings upon the neurotic disorders of chilhood, form the nucleus of the book under review. The author has set forth his views very clearly, and has given us a very readable book, which, while at times tending to prolixity, is always interesting and withal abounding in practical points. A large number of morbid states are considered, and the connection of intestinal toxæmia, reflex irritation, etc., to each condition carefully reasoned out. There is a liberal citation of cases, and here and there the views of the author are emphasized by being typed in italics. The feeling may be engendered that too great importance is attached to the possible autotoxic factor and that the application of the theory is made rather general, but the work is nevertheless one which merits careful study, and which is well worth a place in the library of every well informed physician.

SYNOPSIS OF HUMAN ANATOMY: Being a complete compend of anatomy, including the anatomy of the viscera, and numerous tables. By JAMES K. YOUNG, M.D., Professor of Orthopædic Surgery, University of Pennsylvania. Second Edition, revised and enlarged. F. A. Davis Co., Phila., 1905.

This hand-book on anatomy has now reached its second edition and has been greatly improved, especially by the addition of large number of plates. The illustrations are particularly good, much better than one generally sees in compends on anatomy. The plates showing the distribution of the nerves to the various muscles and organs which they supply, should certainly prove of great assistance to the student or the general practitioner who wishes to see at a glance the distribution of any particular nerve; and for the student the plates showing the branches of the different arteries are very clear, and ought to be of great assistance.

In the preface the author says that he has had to sacrifice elegance of diction, for conciseness and accuracy. Fortunately he has not been tempted to be too concise by leaving out many important anatomical facts, as so often is done in these compends; and consequently we find that the book contains some 400 pages.

The last chapter of the volume treats entirely upon surgical anatomy, and although, as one would expect, it does not cover all the ground on such an extensive subject, the regions that are taken up are treated with conciseness and accuracy, the article on hernia being particularly good.

The volume itself is nicely bound in a flexible cover and should prove a very useful book to those students and medical practitioners who prefer learning their anatomy from compends rather than the more tedious method of reading Gray or Morris.

Medical Journals Merge.—The A. R. Elliott Publishing Company has purchased the *Medical News*, published for sixty-three years by Lea Brothers & Co., and consolidated it with the *New York Medical Journal*. A. R. Elliott purchased the *New York Medical Journal* from D. Appleton & Co. in July, 1900. In June, 1903, he purchased the *Philadelphia Medical Journal* and merged it with the New York publications. The editor of the *New York Medical Journal*, Dr. Frank P. Foster, is one of the most prominent writers in America on the subject of medicine. He became editor of the *Journal* on January 1, 1880. He has now associated with him Dr. Smith Ely Jolliffe, for the last five years editor of the *Medical News*, and a strong board of advisory editors.

MEDICAL AFFAIRS IN ARCTIC REGIONS.

SOME interesting notes made in a summer trip to North Greenland in the supply ship of the Peary expedition are published by Nicholas Senn, Chicago. The Smith's Sound Eskimos met by him are the original unadulterated stock and present many peculiar and interesting racial features, especially as regards their habits and resistance to disease. To their exclusively carnivorous diet Senn ascribes not only their freedom from scurvy, the scourge of arctic expeditions, but also the absence among them of enlarged tonsils and cervical lymphatic glands and goiter, as well as their splendid teeth and strong lower jaws. He suggests that the absence of all vegetable food from the diet has shortened the gastro-intestinal canal, that the appendix, if present, is only rudimentary, and that the glands concerned in the digestion of starchy food have atrophied while those needed in the digestion of meat and the emulsification of fats are hypertrophied. The large percentage of oils in the diet acts as a laxative and protects them from a multitude of ailments with which the physician has to deal in our civilization. Their freedom from skin diseases, in spite of their uncleanly habits, is remarked, and Senn thinks that perhaps their avoidance of the external use of water may be a factor in producing this result. Tuberculosis is unknown among them in their northern home, though they quickly succumb to it when brought to our climate. Venereal diseases take with them a very mild course. Insanity is unknown among them, but in the long winters an anæmic condition develops, and with it certain hysterical symptoms may occur, but the anæmia never becomes chronic. During the summer, there is a corresponding plethora and attacks of epistaxis are common. Degenerative diseases, arteriosclerosis, Bright's disease, etc., seem to be notably absent. Ordinarily, coughs and colds are unknown, catarrhal attacks follow visits to ships and are expected. Introduced epidemic disorders have played havoc among these people, and Senn mentions a sort of arctic dysentery that seems to have started from Finland and traveled nearly around the arctic circle. He suggests that the infection must have been conveyed over the vast uninhabited tracts by migratory birds. The universal epidemic, la grippe, has also helped to decimate these people. The Eskimos appear to have no native medicine, and their ideas of surgery are practically *nil*. Suppurating wounds, however, are rare in the germ-free atmosphere of their habitat. Tumors seem to be unknown, and Senn is inclined to attribute this, in part at least, to the highly iodized meat diet. Their obstetric methods are primitive and childbirth is not a severe operation. Children are nursed until two or more years old, and are generally healthy. He thinks uterine and ovarian diseases are uncommon. In conclusion, he mentions a peculiar distemper of dogs, resembling rabies, but differing in certain respects. Animal parasites, such as tapeworm, appear to be rare.—Jour. A. M. A., November 18 and 25, 1905.

PERSONAL PARAGRAPHS.

Dr. E. V. Hogan has been again afflicted with an attack of rheumatism with somewhat alarming symptoms. He is now, fortunately, showing signs of improvement.

Dr. L. L. Harrison, who formerly practiced at Pugwash, is now associated with Dr. Mader of this city.

Drs. J. W. Daniel, M. P., St. John, and A. B. Atherton, Fredericton, were recent visitors to our city.

Dr. J. I. O'Connell, recently one of the house staff at the Victoria General Hospital, is now settled at Brookfield, Newfoundland.

Dr. Fred Miller, of Charlottetown, who is at the Saranac Lake Sanitarium, is improving in health.

Dr. Allan Cunningham spent the Christmas season with his parents, Dr. N. F. and Mrs. Cuninngham, Dartmouth, and is now at the Post Graduate Hospital, New York.

Drs. P. M. Ryan and Lewis Thomas have been appointed to the Halilax Dispensary staff.

Dr. C. E. Buckley, of this city, is now at the Kentville Sanatorium.

Dr. Robert Grierson, returned missionary from Corea, is home on a visit to his relatives. Dr. Grierson has given several interesting lectures on life in Corea and one on his personal experiences during the Russian-Japanese war.

THE PRESTON CASE.

The trial of Dr. Edward A. Preston, a homeopathic physician of St. John, for manslaughter, ended in his acquittal.

The trial lasted from the 4th to the 9th of January, and excited much interest throughout the community. The presiding judge was Chief Justice Tuck.

It was charged against Dr. Preston that he had procured abortion on an unmarried woman, Edith Clarke, and that death resulted from septicæmia.

During her illness the woman's friends called in Dr. Roberts, who later curetted her, assisted by Dr. Scammell.

The witness Camp stated that he had paid Dr. Preston $25 to get the girl out of trouble.

Dr. Preston swore that he had never done anything to procure abortion, that the woman had said she had done something herself, and that he had treated her with the view to prevent miscarriage.

During the trial there was a large amount of medico-legal evidence given by the physicians connected with the case, also other physicians, and by Dr. G. A. B. Addy, who performed the post mortem examination and found evidence of there having been a miscarriage. As has been stated, the jury brought in a verdict of not guilty.

FOR IDLE MOMENTS.

A DUSKY couple, evidently on their honeymoon, were heard discussing the beauties of the Louisiana Purchase Exposition.

"Dese heah," said he, with a lofty wave of the hand, "am what dey calls de fine Art Buildin's."

"Don't look so terrible fine to me," objected the bride. "De Libble Art Buildin' looks finer."

"It do that," assented the groom.

"What is libble art, anyway?" she inquired sweetly.

He drew himself up and gave her an impressive look. "Libble art," he began, and then pondered a moment—"I don't know as I can give a correck idea of libble art, honey; I know what it is, but I disremember. But it's a mighty fine buildin'. All dese heah buildin's, you know, am in de style of de French Reminiscence."

"Pop!"

"Yes, my son."

"What is a liqueur?"

"A liqueur, my son, is a cordial smile."

A specialist in throat troubles was called to treat a Boston lady, who manifested so much interest in his surgical instruments that he explained their use to her. "This laryngoscope," said he, "is fitted with small mirrors and an electric light; the interior of your throat will be seen by me as clearly as the exterior; you would be surprised to know how far down we can see with an instrument of this kind." The operation over, the lady appeared somewhat agitated.

"Poor girl," said her sister, who was present, "it must have been very painful."

"Oh, no, not that," whispered the Boston lady; "but just as he fixed his instrument in place I remembered I had a hole in my stocking."

Said a broken down fox, "I have spent
Every dollar I had," and he went
To a wealthy old skunk
For the loan of a plunk,
But the skunk wouldn't give him a scent.
—*New York Times.*

Then he went to a mink of high rank,
And he begged for the loan of a franc.
Said the Mink, "Why, old fox,
Here are plenty of rocks.
Help yourself; draw 'em out of this bank."—*Chicago Tribune.*

To a buck then poor Reynard did go,
And he begged for a ten-spot or so;
But the buck said, "I'm broke,"
Which was really no joke,
For this buck didn't have any doe.

When the fox saw the buck had no stake,
He tried "touching" a crane from a lake.
Said the crane, "Now, old boy,
I'd assist you with joy,
But my bill isn't one I can break."
—*Kansas City Star.*

When the crane passed up his advance,
Said the fox, "I'll just take a chance."
A dog, badly "blowed,"
Lay out in the road.
So Reynard just went through its pants.
—*Omaha Druggist.*

"Keep that physician in attendance on our family!" exclaimed Mrs. Parvie New, "Never."

"Has he killed anybody?"

"No. But he had the impertinence to say that Mr. New's blood was impoverished!"

TALK OF THE OFFICE.

THIS is a day of Forward Movements, and the MARITIME MEDICAL NEWS is making one. This is the result of a resolution which we made on New Year's Day, reading as follows:

"*Whereas*, it is evident to us that the MARITIME MEDICAL NEWS can be improved; therefore be it

"*Resolved*, that the MARITIME MEDICAL NEWS *be* improved."

We did not forget this resolution as soon as it was made, and we *won't* forget it. Every month of the present year we will strenuously adhere to our good resolution. We promise not to be a backslider.

One of our first arrangements looking to this end was to improve the get-up of our journal, and we think our readers will fully appreciate the results. It is costing us more, but then our reuders are not asked to pay more, but will have the resulting benefits without further cost. The magazine will be easier to read because of the improved typographical appearance, and because of the change in type measure. Our motive in changing the measure to two columns on a page was to provide greater ease to the eye in following the lines. This measure is used in a great many of the best magazines.

At the same time we undertook to make a change in the management which would relieve the editors of the vexatious details incident to the business end. By this arrangement the editors are now able to conduct their editorial work more smoothly. Instead of writing letters, making collections, adjusting difficulties, etc., which has hitherto taken much of their time, they will be able to use the time that has been so consumed, in considering matters relating to the editorial end. The ownership and editorial responsibilities are retained by the old board of editors, but they are happy to report that they have shifted the business worries to other shoulders. We are sure this will also result in improvement.

So far so good. But our efforts will not end with improving the appearance of the NEWS and geting rid of nasty business worries, which should be quite foreign to professional life anyway. We propose bending our energies to the general improvement of the NEWS editorially so that it will the better fulfil its mission. We have taken as our motto "*Altiora petimus*," which, being freely interpreted, meaneth, "A better effort every time."

One thing we wish you to understand is that the *News* is *your* paper. It was founded by a few members of the profession for the

simple purpose of providing a medium for gathering up the medical knowledge that is made in these provinces and for bringing forward and discussing matters of interest and importance to the profession here. It was not the purpose to make money. As a matter of fact no money has been made by it and probably will *not* be made. We will be quite satisfied if we can make the *News* pay its own way. The only dividends it has paid in the past has been in the way of sacrifices of time. We expect the same in the future. But we won't be sorry, if we have the loyal support of our readers and succeed in fulfilling our mission.

We ask our readers to follow very closely the work we have undertaken, and we ask them not only to take an interest in it, but to criticise it. We want suggestions. If any reader has anything to publish, we want it. If he thinks certain things should be covered, we want to know it. We want our work pulled to pieces. If necessary, you can be absolutely merciless in so dealing with us, for our desire is to produce a journal that will meet the need and we can do that best when we have other ideas as well as our own.

Another thing we ask, namely, that our readers note the improvement in our advertising pages. We are seeking typographical excellence there too. Moreover, the advertising pages are interesting as well as mechanically pleasing, and the reader may find suggestions there worth having. Our purpose is to give our advertisers the utmost value for their money as well as our readers; and as our advertisers are helping us to give our readers a good paper, we hope our readers will help us to give our advertisers this good value.

There is not a registered practitioner in the Maritime Provinces who will not receive a copy of the MARITIME MEDICAL NEWS this month. Most of them are already readers. Some have not been readers. Let us say a word now to the last named. We want you to take an interest in the NEWS, and while we appeal to you on professional grounds, still we feel that we can appeal to you on the merits of the case. Do you not think the NEWS worth a dollar a year to you? There is an application form enclosed. Suppose you fill it out now, enclose it with a dollar in an envelope, and drop it in the post office the next time you are down town, and then note from month to month during the coming year how you will get your dollar back. Really, if we were you, we would subscribe to the NEWS right away.

Some of the articles in this number are papers which were read at the annual meeting of the Canadian Medical Association held in Halifax, and appear here for the first time. Other papers which had been read there have already been published in these pages. To have these in such convenient form would alone be worth the annual subscription to this journal. We will be able to announce interesting features from time to time.

THERAPEUTIC NOTES.

Neuralgias From Alcohol and Opium Excesses.—A recent number of *The Quarterly Journal of Inebriety*, published under the auspices of the American Association for the Study and Cure of Inebriates, Hartford, Conn., U. S. A., says:—

"Antikamnia Tablets are one of the best remedies and are very valuable as a mild narcotic in neuralgias from alcohol and opium excesses. We have used them with best results." *The Edinburgh Medical Journal*—Scotland—says regarding Antikamnia: "In doses of one or two tablets, it appears to act as a speedy and effective antipyretic and analgesic." *The Medical Annual*, London, Eng., says: "Our attention was called first to this pain reliever by an American physician whom we saw in consultation regarding one of his patients who suffered from locomotor ataxia. He told us that nothing had relieved the lightning pains so well as antikamnia tablets, which at that time were practically unknown in England. We have since used them repeatedly for the purpose of removing pain, with most satisfactory results. The average adult dose is two tablets which may be repeated every two or three hours without fear of unpleasant symptoms."

Liquid Antiseptics.— In our advertising pages will be found an announcement of a gold medal awarded to Listerine by the Lewis and Clark Central Exposition. Notwithstanding the numerous other liquid antiseptics revealed to the profession, the original still holds a foremost place.

Sanmetto in Enuresis. — E. Ellis, M. D., Chicago, says: I administered Sanmetto in a case of enuresis—male, six years of age—on whom other experiments had already been tried. The mother reports great satisfaction. The prescription for Sanmetto was only duplicated once and not all of the second quantity used. Thanks from the friends Sanmetto made and the doctor who prescribed the preparation as well.

Pneumonia. — The pneumonia season is rapidly approaching. Soon the various journals will be full of the statistics of past years in regard to the prevalence and fatality of this disease. The pathology and etiology will be thoroughly gone over, but, judging by the past, most writers will have very little that is encouraging to say as regards treatment.

Several points, nevertheless, must be kept in mind. Whatever drugs are used internally (and this depends very much upon the individual case), the patient must have plenty of fresh air. Do not be afraid of his taking cold on account of the cold air blowing

across his face. It is now conaidered that this is impossible. Also, whatever drugs may be used, keep the body warm with suitable clothing, and use externally some preparation which will cause a comparative lessening of blood-pressure in the lungs. Cold applications, besides lowering the vitality of the patient, cause a depletion of the superficial vessels and consequently increase the hyperemia in the lungs themselves. Our attention then would be drawn, per contra, to hot applications. To the most of these there are very great practical objections, such as their inconvenience, their tendency to grow cold very rapidly, and the act that they must frequently be renewed, thereby disturbing the patient's rest to his manifest detriment.

We have found but one form of hot application which seems to us to entirely fill the bill, and that is antiphlogistine. By its means the vitality of the body is conserved, the blood is attracted to the surface and away from the lungs (its hygroscopic action remarkably enhancing this effect), and the tone of the heart's action is maintained. Besides this, its frequent renewal is not necessary, and the patient's rest is not thereby disturbed. Practically we know that by its use the patient is made much more comfortable, the fatality is much more decreased, and if abortion of the disease is possible, we believe it can be accomplished better by this means than by any other.—*Kansas City Medical Record, Oct., 1905.*

THE TREATMENT OF NASAL CATARRH

BY

JOHN A. HALE, M.D.

Alto Pass, Ill.

FOR years I used various remedies and met with varying success, until tiring of one remedy after another I relied solely on Potassium Permanganate in weak solutions as a nasal douche, but a review of some points in this paper wll show why I always sought for something else. Glyco-Thymoline has usurped the place of the permanganate solution in mv armamentarium, and after sufficient trial, established faith, implicit faith, in its specific therapeusis for this condition. A knowledge of its essential constituents and their therapeutic action only tends to strengthen a belief in its specificity. Caution is necessary in the selection and use of remedies, but a fair trial has proven no untoward inconvenience emanating from the use of this remedy. Meanwhile the therapeutic results are gratifying and the good effect of Glyco-Thymoline can be easily verified by a trial, when conclusions will be the result of practical truths only.

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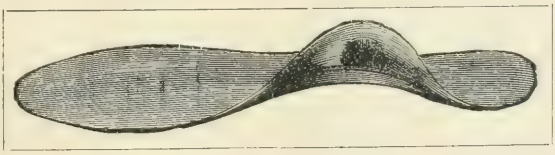

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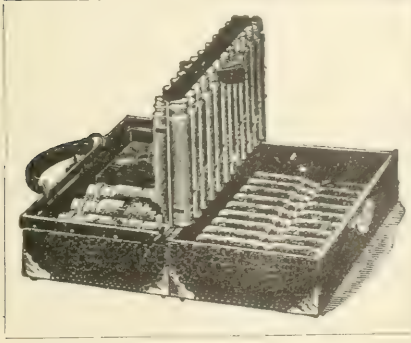

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THIRTY-SEVENTH SESSION, 1905-1906

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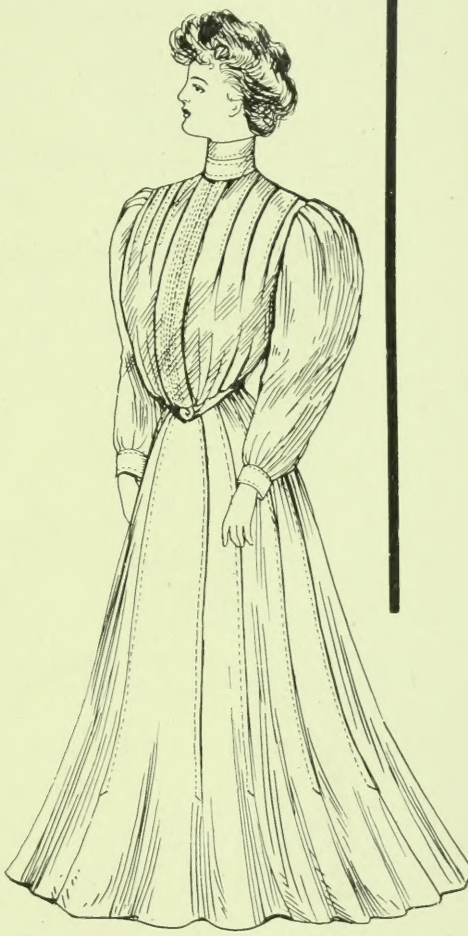

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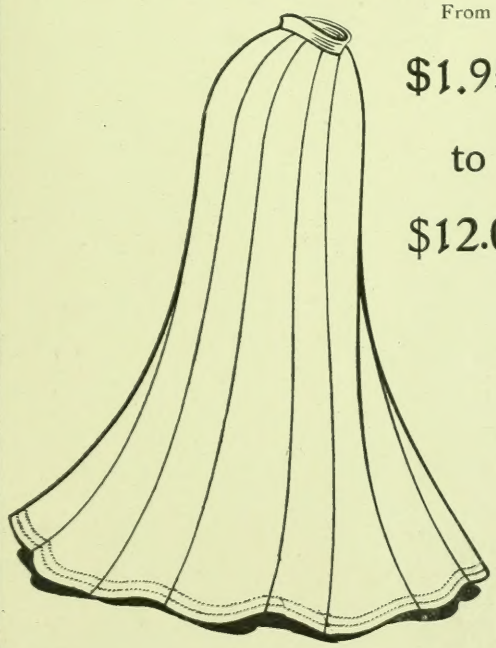

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